**MEETING MINUTES**

| **Project Name:** IPRS | **Doc. Version No:** 1.0 | **Status:** Final |
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| **Meeting Name:** | IPRS Core Team Meeting |
| **Facilitator:** | Travis Nobles, DMH |
| **Scribe:** | Evelyn Woodard |
| **Date:** | 09/12/2007 |
| **Time:** | 10:30 – 11:30 AM |
| **Location:** | Wycliff, Conference Room 429 |

**IPRS Core Team Attendees:**

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| | Gary Imes | **Others:** | |
| x | Thelma Hayter | x | Cathy Bennett |
| x | Eric Johnson | x | Sandy Flores |
| x | Travis Nobles | x | Paul Carr |
| x | Cheryl McQueen | x | Evelyn Woodard |
| x | Joyce Sims | x | Chris Ferell |
| x | Jamie Herubin | x | Rick Kretschmer |
| x | Mike Frost | | Deborah LeBlanc |
| x | Myran Harris | | Tim Sullivan |

**Attendees:**

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| | Alamance-Caswell | x | Johnston |
| x | Albemarle | x | Mecklenburg |
| x | Catawba | x | Onslow-Carteret |
| x | Centerpoint | x | OPC |
| | Crossroads | x | Pathways |
| x | Cumberland | x | Sandhills |
| x | Durham | x | SE Center |
| x | Eastpointe | | SE Regional |
| x | ECBH | | Smoky Mountain |
| x | Five – County MHA | x | The Beacon Center |
| x | Foothills | x | Wake |
| x | Guilford | x | Western Highlands |

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| **Attendees:** | |
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| **Item No. Topics** | 1. Roll call<br><br>2. Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.**<br><br>3. Upcoming Check-writes (cut-off dates) – Sept. 13, 20, and Oct. 4<br><br>4. Agenda items<br>• **New State Rate Report IPPR2419**<br>• **Budget Pend Days Now Set to Zero**<br>• **DMH Implementation Update 33 – Full Endorsement of Providers**<br>• Timely Filing Cutoff – 10/25 Checkwrite<br>• Beta Test (NPI) Requirements Review<br>  • 100 records/LME/submission; Format test; full cycle run, 835<br>  • **Update scheduled termination: TBD**<br>• IPRS Questions or Concerns<br>• MMIS Updates – Tim Sullivan & Chris Ferrell<br><br>5. DMH and/or EDS concluding remarks.<br><br>a. For **North Carolina Medicaid** claim questions / inquiries, please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator.<br><br>i. Physician phone analyst (i.e. Independent mental Health Providers – 4706<br>ii. Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) – 4704<br>6. Roll Call Updates |

**Next Meeting: September 19, 2007**

For assistance with IPRS claims, adjustments, R2Web, accessing application, etc.
Call the IPRS Help Desk – 1-800-688-6696, ext 53355 or 919-816-4355
M-F, 8 a.m.-4:30 p.m., excluding holidays.
IPRS Question and Answer email address – iprs.qanda@ncmail.net

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| ADMINISTRATION NOTES (10:30 a.m. AREA PROGRAMS CONFERENCE CALL) | |
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| **Item No.** | **Topics** |
| 1. | Roll Call |
| 2. | Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. **Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.** |
| 3. | **Upcoming Check-writes** (cut-off dates)<br>Sept. 13, 20, Oct. 4 |
| 4. | **Agenda items**<br>• New Rate Report IPPR2419<br>Rate Report IPPR2419 is a brand new State report. The report has been created but has not been implemented yet. Implementation is expected to take place early this week. LMEs please be on the lookout for this report.<br>• Budget Pending Days Now Set to Zero<br>Formerly the system would pend a claim for insufficient budget for a checkwrite and if was determined there was more money available, those claims would pay in the following checkwrite. This process was setup with the intent that when money was depleted in a particular budget the LME could request additional money to be transferred to that budget. Since the State Budget situation has not been completed and updated in our system and more LMEs are becoming Single Stream, the Division has decided to remove that limitation so that these claims will not pend. If they receive a budget denial code, these claims will deny right away instead of pending for one checkwrite and then denying.<br>Q: Tom (WH) – Are you saying that it won't pend, it will deny, but will it drop down and follow the hierarchy and look for another funding source?<br>A: Cheryl (DMH) – Yes, that hasn't changed. If there is another pop group it can go to, it will go to that other pop group. It's just that it will not sit out there and pend for that week and then go to the next pop group. In the first checkwrite, you will get your EOB-8800 denial code stating there's further processing and then in the second checkwrite it would immediately go to that second pop group.<br>Q: Tom (WH) – So then it will not deny until it has exhausted all of its possible sources.<br>A: Cheryl (DMH) – Yes, it just won't pend them.<br>• DMH Implementation Update 33 – Full Endorsement of Providers<br>Three weeks ago the Division had talked about the cutoff date remaining 9/20/07. They were concerned that those providers weren't fully endorsed and that they would not get paid. The Update 33 explains the changes to those dates and the deadlines for endorsements. The Division encouraged all LMEs that had not read this update to do so because it is very informative. If the LMEs have any questions regarding Update 33, the Division encouraged them to send those questions to IPRS Q&A. The Division can forward the questions on to Christina or if the LME wish to discuss the update during Core Team, they are welcome to do this, too.<br>Q: Tom (WH) – Angela, in the DMH Implementation Update 33, it gives the November 30th as the LME Decision Date and the Medicaid Provider Number End Date as December 31st. What does that Medicaid Provider Number end-date mean?<br>A: Angela Floyd (DMH) – Community Intervention Service providers currently in our system were end-dated 9/20/07. That means that in our system we had a hard date that says 'September 20th Your Medicaid Provider Agreement Terminates'. We moved that date out to December 31st to allow LMEs time to continue with the |



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endorsement process and to allow the providers after LMEs endorsement time to get their applications in to us before December 31st. If you read further down in that document, if a provider submits their application with all attachments in our office by December 31st, they should not experience any interruptions in their payment.

Q: Tom (WH) – Is the full endorsement still for a 3 year duration?
A: Angela Floyd (DMH) – There is a draft policy manual at the bottom of this bulletin and basically in that draft it talks about conditional endorsement ceasing and it was discussed during training, too. Either the provider gets fully endorsed after October1st or they do not get endorsed and we talked about this in previous meetings, it is a minimum of 1 year and the maximum of 3 years.
Q: Tom (WH) – For those providers that are conditionally endorsed is the term still 3 years?
A: Angela Floyd (DMH) – Yes. If these are the providers that were given 18 months and you look at this on the last page of the bulletin, the first bullet on the third page, it says all providers of services in phases I, II, and III conditionally endorsed prior to 4/1/07 must be fully endorsed by 11/30/07. Any provider who came in after that will be given one 6 month conditional and then after that they must have full endorsement.

- DMH Implementation Update 34 – Various Updates
  The Division received a memo from DMA stating that the Behavioral Health Policy Unit has created a Training and Technical Assistance team to address the volumes of providers' inquiries regarding Medicaid service implementation assistance. The team will work closely with the LMEs and the provider staff. The intent of the team is to better ensure consistent implementation of DMA Requirements and Service Definitions. There are three names listed on the memo including their contact numbers. The LMEs can now contact these individuals directly for these types of questions instead of emailing them to IPRS Q&A.

  Q: Tommy (Sandhills) – If we have a provider that we have pulled their endorsement for a service and now they are in the appeals process stage, can they continue to bill?
  A: Angela Floyd (DMH) – No, we want. If the provider appeals, we have in regulations and administrative codes that once endorsement has been withdrawn, we terminate the provider even while they are waiting appeal. The only time that we had to back away from that is if the provider goes forward with an injunction and the administrative law judge gives them a stay, then we have to reverse that, but I've only seen that happen in one case.
  Q: Tommy (Sandhills) - So when you all get a copy of the letter that we have sent to the provider you pulled their numbers at that point?
  A: Angela Floyd (DMH) – That's correct. Our administrative codes state that we terminate them while waiting appeal.

  Q: Tom (WH) – Could you please tell me when DMA applies the effective date of full endorsement for any of the community intervention services?
  A: Angela Floyd (DMA) – We've been trying to be consistent, but over time things have changed and the date we are using now is the date of the endorsement.

  Q: Tom (WH) – Could you please clarify what that means?
  A: Angela (DMA) – If you send a DMA letter for a provider and they attach it with their application the endorsement date of January 1st[s]through December 31st and we review it in February, then we would give the endorsement date to match the endorsement date as January 1st[s]. However, the caveat to that is that we are not all encouraging the provider to provide services with Medicaid before they are enrolled, because until that number is issue we are not guaranteeing that we are going to approve it. The other issue is that with Value Options and with

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authorizations they will not do any retroactive services. So if providers decide or choose if they want to go ahead and provide services and they feel confident that we are going to approve them, we do not endorse that. But if they do that then and any services that needed authorization, they will not receive reimbursement for it..

Q: Tom (WH) – I think so. The example you gave 'the endorsement date of January 1st's through December 31st and they submit it in February, then services in January and February are payments contingent upon DMA's acceptance of that application and the effective date would be January'?
A: Angela Floyd (DMA) – It may be if they meet all conditions of participation, then we would go back to the date of endorsement. If there were some other special requirements that they didn't meet until February then we would go back to the February date. We do not encourage providers to begin providing a service before they have Medicaid enrollment and it has been confirmed.

Q: Thelma (DMH) - And especially on all the endorsed enhanced services, they all require Prior Approval, right?
A: Angela (DMA) – I believe so.

Q: Thelma (DMH) – So if they were providing services in January and they get approved by DMA in February to go back to January and there was no Prior Approval on that service is not going to be paid right?
A: Angela (DMA) - That is correct.

Q: Terry (Eastpointe) – Angela, we received a question from the provider regarding clients that came in as IPRS clients. We sent these clients to the providers for services and in the meantime, we helped them to become Medicaid eligible. IPRS then recouped the money for them and we had already paid the provider when we were paid. The providers are now stating they cannot bill Medicaid for these services because in the beginning for IPRS, the clients did not need to have a diagnostic assessment. Medicaid is requiring the clients to have a diagnostic assessment and services billed are for Community Support. Medicaid is stating the LME cannot bill these services. Is there anything in writing that states this?
A: Angela (DMA) - I am not sure. I think I need to speak with Tara Larson regarding this. I need to get more information about that. Could you please send me an email about that?
A: Terry (Eastpointe) – Sure, what is your email address?
A: Angela (DMA) - It is angela.floyd@ncmail.net.
A: Terry (Eastpointe) This is happening a lot where clients are retroactive Medicaid then we are the ones without the money.
A: Angela (DMA) – Right, but my fear is that if the Medicaid requirements for the service definition are not met, we should be paid and I am afraid that is going to be Tara's answer as well. So if you can send me some specifics, Tara and I can discuss this.

- Timely Filing Cutoff – 10/25 Checkwrite
  N/A

- 837 Beta Test (NPI)
  Catawba County sent in two beta test files and Johnston County sent beta test files. The Division encouraged the other LMEs to submit beta test files now.

- Medicaid Updates, Questions or Concerns
  Linda Pruitt is the New Manager for Medicaid Provider Services for DMA. She has a wealth of knowledge and experience with Medicaid; DMA is excited to have her on their team.

  Q: Angela (Sandhills) – I have two Medicaid questions. The first one is regarding

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procedure code H0004 and all of its modifiers. We have been receiving denial codes stating we need insurance and/or Medicare needs to be filed. Back in October 2006, I sent an email to Carol Robertson asking if this procedure code was subject to Medicare or third party insurance and she told me no. Since that time, I have been working with Carol Robertson and Simpson, her predecessor, trying to see why we cannot get the edits back in place so that we can just file Medicaid for this procedure code and I keep getting told that it is being worked on. Can anyone tell me where that stands with Medicaid?
A: Chris (EDS) – If you can send that example with those comments to Q&A, we can follow-up with Carol's replacement and see where this is.
Q: Angela (Sandhills) – My other Medicaid question is simple. Our most recent RA is not here. We have our Multi-Specialty RA's but not our Base RA's. Are these being printed late?
A: Chris (EDS) – No, all of the RA's should have been mailed out at the same time. If you call in to the EDS Help Desk, they will be able to order you another one and get the second one shipped out for free. You may want to verify your address to make sure that everything is correct to make sure we are sending your RA's to the correct place.

- IPRS Questions or Concerns

Q: Tom (WH) – In the September 2007 Medicaid Bulletin, DMA advised providers to educate their staff, and then provide a letter stating that they educated their staff on the False Claims Act. Are fully divested LMEs exempt from this requirement?
A: Thelma (DMH) – We received your question earlier and we forwarded it to other staff members. We have not received an answer from them yet. I will follow-up with Christina.

Q: Sandhills – What is the status of the Telemedicine psychiatry codes?
A: Thelma (DMH) – The codes are still being tested. We are in communications with Medicaid in order to coordinate a simultaneous implementation. Hopefully both divisions will be able to implement at the same time.

Q: Beth (Pathways) – I have a question regarding DMH Implementation Update 34. I am looking here at the target case management reimbursement where we were told multiple times not to give out our LME providers numbers, and here it is telling us that we can. So we are contemplating doing that, but I wanted to find out while we were on the call if there any other LME who have already been doing this. If someone could contact me and let me know how that works, because it would be my understanding that the provider would then bill their own targeted case management using our Medicaid provider number. The RA and the money are going to come back to the LME and therefore we have to figure out a way without posting payment into our system, because the events will not be in our system. We have to figure out a way to divvy that money out and who it belongs to, etc. I'm just trying to gather data right now for our management team in order to figure out whether or not we want to do this. Of course, it would be great if we have to worry less about billing, but if it is going to cause us three times the headache when it comes back in, then we do not want to do it, because we do not have the staff or man power to do that. If somebody could let me know if they have been doing that and how that's working, that would be wonderful information.
A: Kelly (Durham) - We started this two weeks ago based on approval from DMA. We talked with Tara Larson, so you can give me a call.
A: Lynn (Five County) – We also do that, if you want to call me.

Q: Tom (WH) – Among that DMH Implementation Update 34, it says something to the effect about Value Options accepting Retroactive Medicaid up to 90 days, but there are instances where a consumer receives Retroactive Medicaid greater than 90 days. Just wasn't sure whether that was still acceptable, if the policy has changed,

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| | or what the intent is on that implementation update.<br>A: Chris (EDS) – If you could send this to Q&A, most of the Retroactive Medicaid issues are going to be about 90 days and if you've have an example of a recipient that is over 90 days, could you please put that in your comments? That way we can take this to DMA and have them tell us what they think.<br>Q: Tom (WH) – I do not have an example to present to you, but it is a common occurrence, so I would like to know if that was misstated in that communication and that DMA does or does not accept Retroactive Medicaid for greater than 90 days?<br>A: Thelma (DMH) – Actually, that might be a very good question to send to Marie Britt, Simone Chessa, and Bert Bennett and they may be able to give you the update on that policy. If you still wish, you can forward this question to Chris and DMA, but I believe that is what the new team is for: to help answer those types of questions.<br>Q: Tom (WH) – Do you want me to email Chris and ask for clarification on that?<br>A: Thelma (DMH) – Talk with Marie Britt, who is the person listed as technical assistance for DMA Behavioral Health Policy and see if she could answer that question about the greater than 90 day time period for the Retroactive Medicaid.<br>Q: Tom (WH) – How do I contact Marie Britt?<br>A: Thelma (DMH) – Her phone number is on the memo, it is 910-674-4226. If she is not able to answer or feels that this is not in her area, then send your concern to IPRS Q&A.<br><br>Q: Terry (Eastpointe) – I have an IPRS question. Do you all have any idea when the budget will be loaded?<br>A: Thelma (DMH) – We don't know.<br>A: Terry (Eastpointe) – ok. We keep getting denied for a bunch of services on a certain pop group and I was just wondering when it will be loaded.<br>A: Thelma (DMH) – Kent is the one who probably has the most accurate information on that. We are in contact with the budget office in order to receive updates on the status of the budget load. We will send an update to the LME community when it is loaded.<br><br>**DMH and/or EDS Concluding Remarks:**<br><br>For North Carolina Medicaid claim questions / inquires please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator.<br>o Physician phone analyst (i.e. Independent Mental Health Providers)-4706<br>o Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) - 4707<br>**Roll Call Updates** |
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